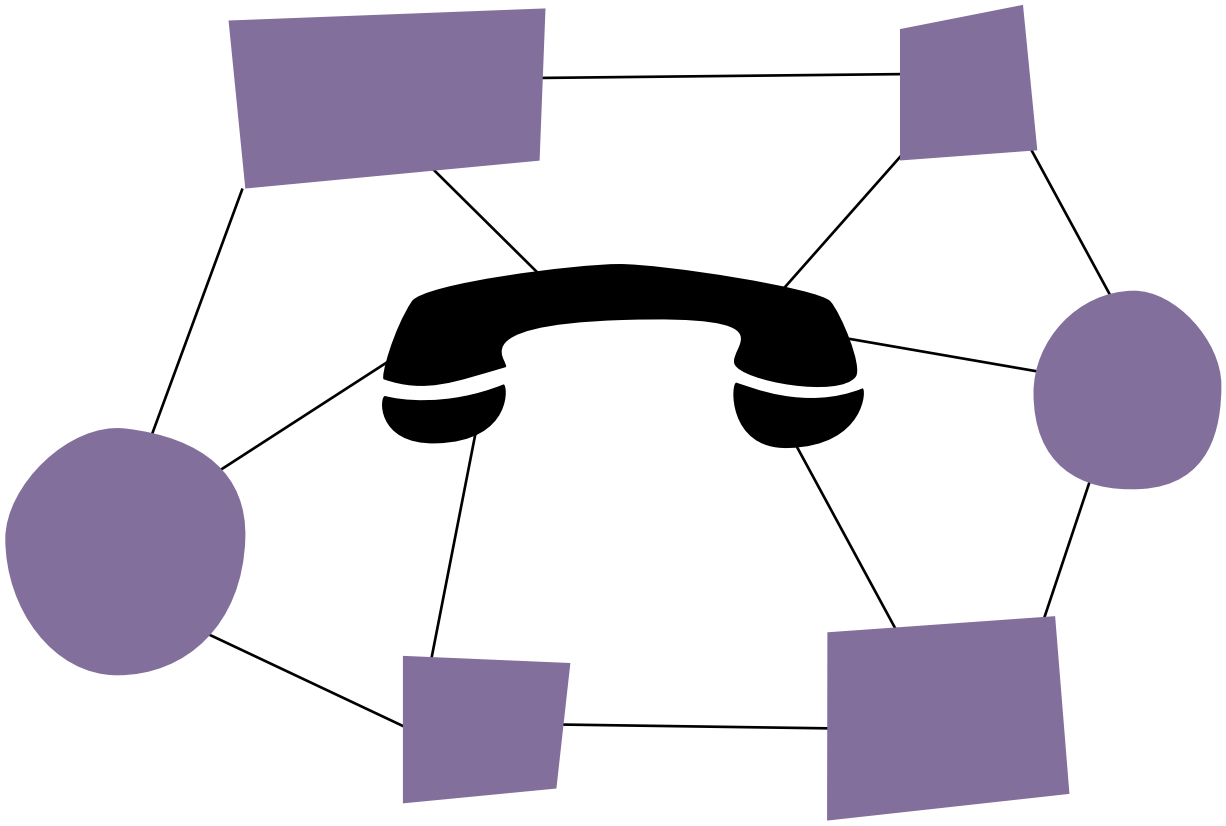
A REPORT OF THE PACIFIC CENTER ON HEALTH AND TOBACCO

LINKING A NETWORK:

Integrate Quitlines with Health Care Systems



A REPORT OF THE PACIFIC CENTER ON HEALTH AND TOBACCO

Linking a Network: Integrate Quitlines with Health Care Systems

July 2003

Acknowledgement

The members of the Pacific Center on Health and Tobacco gratefully acknowledge The Robert Wood Johnson Foundation for granting the funds that support our collaboration

PACIFIC CENTER ON HEALTH AND TOBACCO
LINKING A NETWORK: INTEGRATE QUITLINES WITH HEALTH CARE SYSTEMS

Table of Contents

PACIFIC CENTER ON HEALTH AND TOBACCO
LINKING A NETWORK: INTEGRATE QUIT LINES WITH HEALTH CARE SYSTEMS

Introduction

There is no question that people who use tobacco face serious health consequences and that effective treatments could help many tobacco users quit. Clear guidelines are now available to inform decisions about effective treatment, but putting these guidelines into practice is challenging.

The Pacific Center on Health and Tobacco (PCHT), a multi-disciplinary coalition from five Western states, has collaborated on a comprehensive approach to statewide tobacco cessation programs. PCHT includes representatives of business, health plans, advocacy coalitions, health departments, and research groups and universities from California, Oregon, Washington, Arizona, and Hawaii. This document and the other Pacific Center tools and reports (Appendix A or www.paccenter.org) support the mission of the PCHT: to promote widespread adoption of evidence-based methods for improving the availability and accessibility of tobacco cessation services within the Pacific Center states and to share our learning with other organizations and states.

The PCHT comprehensive approach to statewide tobacco cessation calls for the development of a network of services, with quitlines as a central resource for services and information, that is able to reach all tobacco users. Funding this network of services would happen through public/private partnerships supporting a variety of covered benefits.

Quitlines are important to the network of services because of their effectiveness and potential for reaching a broad audience, ability to link with a variety of health services, and ability to provide the necessary economies of scale. But they are only a part of the solution. Partners, including health care providers, businesses, insurers, government agencies, and community programs can expand the opportunities for quitlines to reach more people, stabilize funding, normalize quitting, and integrate quitline services with services in health systems.

This report, which includes a variety of practical examples, is divided into three sections:
1. Trends for expanding and integrating quitlines with health systems;
2. Issues for integrating quitlines and health systems;
3. Case studies describing how quitlines integrate with health systems' cessation activities.

Evidence-based recommendations, combined with the applied experience and insight of PCHT members and consultants, form the basis of this report. As additional evidence-based information becomes available and our collective experience grows, this report certainly will evolve.

Substantial research demonstrates that treating people for tobacco dependence is both clinically effective and cost-effective in comparison to other types of medical and disease prevention interventions. Evidence also supports the use of quitlines as an effective population-based treatment strategy. The Pacific Center has based its discussions and applied recommendations, including the role of quitlines as a central resource for managing cessation information and services, on this body of evidence.

The evidence, summarized in Appendix C, includes *Best Practices for Comprehensive Tobacco Control Programs,*[1] the guidelines developed by the Centers for Disease Control and Prevention (CDC); the Public Health Service's comprehensive clinical practice guideline, *Treating Tobacco Use and Dependence;*[2] and the Task Force on Community Preventive Services' Recommendations in the *Guide to Community Preventive Services.* [3]

Also pivotal to the Pacific Center report is the analysis and prioritization of 50 preventive services by Coffield et al., published in the American Journal of Preventive Medicine.[4] (We will refer to these documents as: CDC Best Practices, PHS Clinical Practice Guideline, USPSTF Community Preventive Service Guidelines, and Coffield, 2001.).

This report complements the CDC's Quitline Resource Guide, which outlines the operational details of setting up, monitoring, and evaluating quitlines, which is outlined in Appendix B. A complete copy can be found at http://www.cdc.gov/tobacco.

CURRENT TRENDS

Convergence of Quitlines and Health Care Services

The tobacco control movement has been successful in reducing tobacco use rates by helping some smokers stop and preventing young people from starting. But, actual quitting rates are still low. One estimate is that only about 2.5% of smokers quit smoking permanently each year.[1] The low rate is partly because less than half of smokers try to quit in any given year and because most who do relapse soon afterward.[5]

The evidence base used by the PCHT summarizes recommendations for promoting quit attempts and helping tobacco users stop within a variety of clinical and community settings (see Appendix C). Implementing these recommendations, summarized as the "5A's" (Ask, Advise, Assist, Assess, Arrange), has been the focus of many projects within health care systems.[2] Within the "5A's" framework, health care clinicians provide brief cessation interventions, followed by more intensive cessation services, including counseling and medications.

The result of these clinical and community efforts so far has been mixed. In a recent survey, about half of smokers said they received smoking cessation advice from their physicians in the past year and only a quarter reported receiving any further counseling or medications.[6] A lack of time or training may hamper a clinician's ability to independently provide all of the treatment recommendations.[7] However, clinicians can readily refer a patient for tobacco dependence treatment in the same way he or she refers patients to other specialists if a referral resource is available.

Also included in the evidence-based recommendations is the use of tobacco quitlines for providing tobacco dependence treatment. The effectiveness of quitlines for helping tobacco users has been well established.[2,8,9,10] Further, when quitlines are promoted as part of a state tobacco control media campaign, the number of tobacco users attempting to quit also increases. The potential of quitlines to have a meaningful impact on statewide cessation rates has already led over 30 states in the U.S. to establish quitlines.[11]

But, quitlines are only effective as tobacco users find out and use them. Promoting quitlines through mass media campaigns is effective, but also expensive. The need for a variety of promotion strategies has led some quitlines to develop partnerships with health care systems and community organizations to help establish a quitline referral network.

The need for quitlines to generate referral calls and the need for health care systems to have a resource for referrals has given rise to innovative approaches for integrating quitline services as a referral resource for health care systems. A quitline is an apt referral resource because telephone services are highly accessible and counselors can receive specialized training ensuring quality, evidence-based treatment. Tobacco users are also more likely to use telephone counseling than to participate in other types of counseling, such as groups.[12] Once a tobacco user enrolls in a quitline program, a counselor can proactively call the tobacco user to provide the critical support needed to prevent relapse.[7]

There are a variety of quitline and health care referral projects underway in several states. These projects are of particular interest to the PCHT since they provide models for states to guide the development of a network of services. The following section briefly describes six such projects.

Quitline and Health Care Referral Projects

Health care referral projects are experimenting with ways to encourage providers to refer patients to quitlines for information, counseling, and referral to local services. Some projects promote quitlines to clinicians, urging them to encourage patients to call. In others, insurance companies partner with quitlines to provide services. Other innovations include proactive fax referrals by physicians, free nicotine patches, provider training, and voucher systems for medications. The following describes referral projects in six states.

California Reaches Out to Health Care Providers, Insurers

The California Smokers' Helpline, in an effort to expand outreach beyond tobacco control media, contacts physicians at conferences, special events, and other tobacco control programs. Representatives promote the Helpline as an extension of a clinic's services to help smokers quit. The model encourages providers to "Ask" patients about their tobacco status and "Advise" tobacco users to quit, then to give patients a wallet card with the Helpline toll-free number, encouraging them to call for assistance in quitting. Once the patient calls and enrolls in the Helpline program, a counselor proactively follows up with each patient.

The Helpline periodically sends thank-you letters to health care providers who refer patients, letting them know their referrals make a difference. The Helpline also takes advantage of opportunities that help motivate providers. For instance, after Medi-Cal started paying for nicotine replacement medications for Helpline enrollees, the Helpline began sharing its data about the effectiveness of the Helpline to encourage providers to make a referral. Now over 2,000 providers participate in this program and data show that patients who receive more Helpline counseling with medications are more likely to be abstinent than patients who receive medications but drop out of the counseling.[13]

The Helpline also has expanded its collaboration with health plans, specifically Kaiser Permanente of Northern California. Kaiser now covers cessation medications for members who enroll in the Helpline program. Additional health plan collaborations are underway.

Fax Referral Program Helps Motivate Oregon Tobacco Users to Quit

The Oregon Tobacco Quit Line, designed to provide quitline counseling to all callers, refers callers to more intensive services covered by health insurance whenever possible.* For five years the Quit Line has collected data from insurance companies about their tobacco cessation benefits to include in the referral database, and has also provided insurers and clinicians with promotional materials, including letters, newsletter articles, and a video. The video, distributed to clinics, shows what happens when a patient calls the Quit Line and is also used in "5A's" trainings. As a result of the outreach, provider referrals have steadily increased. Over the course of five years, provider referrals have become the second highest referral source, bringing in 13.6 percent of the calls. Television still is the primary source for Quit Line calls.[14]

Starting in 2001, Oregon began testing another form of outreach: a proactive fax referral. In a pilot project with the Medicaid health plan CareOregon, providers and clinic staff completed the first "3A's" (Ask, Advise, Assess) with tobacco users. They then asked the tobacco users who were ready to quit to authorize a referral to the Quit Line. The tobacco user suggested times he or she would be available for a call. Then, a faxed referral spurred a call from a Quit Line counselor at the time indicated by the tobacco user. After the counselor completed the counseling, he or she faxed the results back to the referring provider. If the caller was willing and eligible through covered benefits, he or she was enrolled in a telephone counseling program for follow up.

*The Oregon Tobacco Quit Line was temporarily suspended since April 2003 due to legislative budget cuts. The Quit Line is expected to resume in the fall of 2003.

CareOregon promoted the project to its clinic managers and health care providers, offering a $10 reimbursement for each referral. Initial data showed promising results. Among the referrals, 17 percent were actively quitting at the time they were called, compared to five percent of typical Quit Line callers. Most had not quit when they were initially referred, but said they had quit by the time the Quit Line contacted them, up to a week later.[15]

Provider participation in the fax referral program, however, was sparse. Only six percent of the health care providers participated. Further evaluation and refinements are underway to improve referral rates.

Arizona Program Provides Training, Fax-Referral Options

In 2003, the Arizona Smokers' Helpline and the HealthCare Partnership Continuing Education and Training Unit launched its fax referral program for health care providers. Clinicians involved in the program are trained by the HealthCare Partnership Unit Speakers' Bureau on how to deliver brief cessation interventions and refer patients into a cessation program using the Helpline. Health care providers receive materials, such as patient chart stickers, information cards, magnets, and waiting room posters.

A trained provider, with a patient's consent, can fax a referral form to the Arizona Smokers' Helpline. Within 48 hours, the Helpline confirms receipt of the fax and calls the patient to offer services, which can include information, self-help publications, multi-session telephone counseling, referrals to classes in the community, and a menu of bilingual services. The Helpline then reports the outcome of the referral back to the health care provider. The Helpline markets the training and referral system through exhibits at conferences and by direct mail to providers who have contacted the Helpline or made a referral.

Prior to the launch in 2003, the Helpline tested this referral program with Mohave County Tobacco Use Prevention Program and Mohave County's Women, Infants, and Children (WIC) Program for more than a year. Data from the pilot test showed an 81 percent increase in enrollment into cessation services by Mohave County residents and a 226 percent increase in enrollment by Mohave County WIC participants.[16]

The program is funded through the Arizona Department of Health Services Tobacco Education and Prevention Program (AzTEPP).

Patch Boosts Interest in Minnesota Helpline

When the Helpline began serving adult tobacco users in 2001, it was designed to help uninsured callers or those with little or no cessation coverage. Callers insured for tobacco cessation services are referred back to their insurance carrier. Insured callers who have previous, unsuccessful experience with covered services, who do not think the covered service would help, or who are unwilling to pay the required benefit co-pays can receive counseling through the Helpline.

Helpline counseling begins with a single session initiated by the caller. An additional four-call counseling program is available to those wanting more support and who are eligible. Initially, the Helpline did not provide nicotine gum or patches and about 10 percent to 15 percent of callers enrolled in the four-call counseling program.

In September 2002, the Minnesota Tobacco Helpline started offering free nicotine patches to any caller who enrolled in the four-call counseling program, rapidly boosting enrollment. Over a two-month period, the Helpline received over 8,000 calls, with nearly 60 percent choosing the four-call program option. The free-patch offer received statewide media attention, but was not otherwise promoted through paid advertising.

Maine Conducts Outreach and Adopts Medication Vouchers

The Maine Tobacco HelpLine has been offering multiple-session counseling to any resident since mid-2001. HelpLine services are widely promoted through the media and through health systems, including the Bureau of Health Services (Medicaid). The HelpLine also supports a statewide comprehensive training program for health professionals and uses an "academic detailing" model to bring office-based education and practical tools for providers and staff.

In 2002, the Medication Voucher Program was introduced and provides nicotine gum or patches for those without insurance coverage for these medications. This includes the 25% of Helpline callers who are uninsured. The Medication Voucher Program is accessed through the HelpLine and provides callers up to eight weeks of medication if they are ready to quit and agree to a program of follow-up calls. The vouchers can be redeemed at any pharmacy in Maine. The HelpLine faxes an authorization form for eligible callers to the state's pharmacy benefit manager, who then calls the pharmacy with the participant and medication information. The Voucher Program is a paperless process and ensures that pharmacy professionals across the state play a role in delivering services.

With the addition of the clinical outreach and Voucher Program, about one-fourth of HelpLine callers now report that their call was prompted by information from their health care provider. And, 40 to 50 percent of all smokers calling the HelpLine receive a medication voucher with most of these smokers enrolling in multiple counseling sessions.[17]

Massachusetts Links Providers and Patients to Proactive Telephone Counseling

QuitWorks is a partnership between the Massachusetts Department of Public Health and eight commercial and Medicaid health plans in Massachusetts linking the patients of 12,000 physicians and dentists to proactive telephone counseling and all other treatment resources.

QuitWorks provides health care providers at the major health plans across the state with a simple turnkey approach to treating their patients who smoke by linking them to the state's full range of effective tobacco treatment resources. QuitWorks services include multi-session telephone counseling, referral to community tobacco treatment services offered by certified providers, and follow-up support. Central to the project is a common patient referral form and office practice system, for use by all plans and providers, regardless of patient health plan status. All physicians in Massachusetts have access to the QuitWorks kit containing all the tools needed, including office systems tools, guidance referral forms and patient educational information. Kits have been delivered to hospitals, managed care organizations, and physicians' offices throughout the state by health system representatives.

By working together, Blue Cross Blue Shield of Massachusetts, Boston Medical Center/HealthNet Plan, Fallon Community Health Plan, Harvard Pilgrim Health Care, MassHealth, Neighborhood Health Plan, Network Health and Tufts Health Plan are improving access to a state-of-the-art smoking cessation service. QuitWorks is supported by the Massachusetts Medical Society, Massachusetts Dental Society, Massachusetts Academy of Pediatrics, the American Cancer Society, the American Heart Association, the American Lung Association and the Massachusetts League of Community Health Centers. The extensive network of partnerships developed through QuitWorks has sustained the project despite budget cuts to the state tobacco control program.

ISSUES FOR INTEGRATION

The PCHT proposes a statewide network of cessation services to deliver treatment to all tobacco users. Quitlines and healthcare systems are central to this network. Working to integrate quitline services with services in health systems poses several issues.

Role of Quitlines and Quitline Funding in Statewide Tobacco Cessation Programs

A quitline serves a central role in a statewide network of cessation services. As the public face of tobacco cessation in a state, a quitline can help normalize the seeking of services—and can target its message to specific populations. For example, the Maine Tobacco HelpLine reports reaching young adults and the uninsured, groups with some of the highest smoking rates, who may not have access to other treatment services.[17] The California Helpline has tailored promotions for multicultural audiences and offers counseling in multiple languages. Helpline data shows that the proportion of callers from each of the major ethnic groups in California nearly matches the proportion of smokers in each ethnic group in the state.[18]

Quitlines need to be funded adequately to serve its functions. They need to be advertised and promoted to prompt tobacco users to call. They need adequate staffing, day and evening, and sophisticated call center technology to respond to caller demand. They need services in multiple languages to assist with calls spanning multiple cultures, some of which have high smoking rates and no other services available.

To help with funding, the PCHT recommends that a portion of any new revenue generated from tobacco taxes be earmarked for statewide tobacco control programs. Part of this money needs to be appropriated for adequate funding of quitlines. PCHT also recommends cost-sharing strategies. (See Appendix C for a discussion of quitline costs).

Role of Health Care Systems in Statewide Tobacco Cessation Programs

Health care systems are integral to a statewide network of cessation services, helping to improve promotion of services, distribution of medications, and to stabilize funding. Many tobacco users see a health care provider annually and seriously consider the provider's recommendations about quitting. Through those conversations and subsequent referrals, health care providers help their patients make appropriate use of quitline services. Health care delivery systems, including insurers, can encourage clinicians to help tobacco users quit and refer patients to quitlines when appropriate.

There are multiple examples of such partnerships. In 1992, the California Helpline sought to increase non-media avenues for reaching tobacco-users. In that year, they tallied 75 calls a month from non-media sources, including tobacco users referred by health care providers. In 1999, nearly 20 percent of the Helpline's calls were referred by health care providers.[13]

In 1992, Group Health Cooperative (GHC) sought to increase provider referrals to its Free & Clear telephone counseling program. The Seattle-based health maintenance organization made enrollment in Free & Clear a requirement for receiving medications, promoted the telephone cessation services to members through a quarterly magazine and, in 1996, offered full coverage for the program. Today, approximately 4,500 GHC tobacco users annually enroll in Free & Clear's telephone-based services—more than double the number enrolled prior to 1996. Referrals from primary care providers are the largest source of enrollment.[19]

Health care delivery systems can also play an important role in ensuring that cessation medications are available to all tobacco users. Washington, Oregon, and Minnesota quitlines dispense over-the-counter medications, which are mailed free for eligible callers. Arizona provides discounts. California and Maine offer vouchers that can be redeemed medications at pharmacies. Few state quitlines can afford to assist with prescription medications. Many are not funded to provide any medications. Because effective treatment includes both counseling and medication, health systems can fill a critical gap by assuring that cessation medications are covered for all members who need them.

These kinds of public-private partnerships between quitlines and the health care delivery systems not only enhance cessation services, they can help sustain tobacco programs for the entire state. Funding for state tobacco control programs and quitlines is regularly challenged in state budgeting processes. As links between health systems and quitlines grow, health systems may have a greater investment in helping to protect future funding.

Quitlines as a Disincentive for Health Systems

Creating a statewide cessation services network requires financial support. In most states, publicly funded quitline services cannot provide the full range of effective services tobacco users need to quit. Yet, some health systems, eager to control costs, may see even modest quitline services as sufficient and thus resist covering the additional services needed by members.

However, if quitlines and health systems can develop working partnerships, together they could promote the development of a network of services and offer stable and effective services to broader populations. For example, The Next Generation California Tobacco Control Alliance has created a coalition of health insurers, health care providers, and purchasers to collaborate on an initiative to help fund services.

Other states provide different models. From the beginning, Minnesota and Oregon designed their state quitlines to include a major role for health care. In Massachusetts, a strong, collaborative relationship with health systems was developed to help sustain services as state program funding diminished.

Cost Sharing

The need to create partnerships to increase the potential reach of services comes with practical considerations about paying for the services. Cost sharing between state-funded quitlines and health systems is a logical solution that has the potential to reach more tobacco users, promote a broader investment in a statewide network of services, and create an adequate and stable source of funding.
Several states provide examples of cost-sharing:

- Washington: State funds through the quitline help pay for intensive telephone counseling services for uninsured residents and Medicaid callers. Insured callers are referred to their health plans for more services. Any Washington resident can receive quitline counseling when they call.
- Minnesota: The Helpline is designed to triage callers to their health plans for services, but will provide counseling and medications for any caller needing services, including some callers with private insurance.
- California: The Medicaid program pays for medications for those enrolled in the Helpline telephone counseling program.
- Oregon: The Medicaid program pays for medications. Several health plans who provide Medicaid receive a volume discount for jointly buying quitline counseling services for their respective members.

- Arizona: Some health insurance companies now cover cessation medications and collaborate with the Helpline to link callers to their medication benefits. Helpline counselors are trained to explain benefit information and send tailored benefit information packets to callers.
- Utah: The Medicaid program helps to support quitline services and activities that serve the Medicaid population.
- Massachusetts: The state funds the Helpline. Health plans cover medications and contract with the state funded Resource Center for customized services.

Quitlines as a Future Tobacco Cessation "Super-Service"

The PCHT envisions future quitlines evolving into a central resource that fosters partnerships by helping manage cessation information and services that are cost-effective and highly accessible. In this future role, quitlines could increase both the quality and variety of services to more effectively reach tobacco users, and form stronger links with cessation services in health systems and other community services.

The potential for quitlines to become a central resource lies in their versatility. Quitlines are effective, highly accessible, and can be easily promoted to a wide audience. They provide economies of scale that can make cessation services affordable and widely available. They can screen and triage large numbers of callers into a variety of services. They easily fit into referral systems for health care providers. They can be integrated with other systems, including those that distribute tobacco cessation medications and other population-based approaches to cessation. And quitlines, when used as a centralized resource for a variety of cessation services, can assure quality standards for services.

Presently, state quitlines typically reach 1-2% of the smoking population annually—a level of service that will need to increase for quitlines to have a greater impact on smoking rates.[20] (Also see quitline case studies.) The limited reach of quitlines is a reflection of limited funding. Applying the existing knowledge about improving quitline reach and effectiveness, future, better-funded quitlines could annually reach an estimated 15 percent of the smoking population.[21] Data from Group Health Cooperative of Puget Sound has shown that when even 7 to 8 percent of smokers use the Free & Clear quitline, the overall smoking rate in the membership declines significantly compared to overall smoking rates in Washington state.[19]

The super-service quitline would function as a state tobacco cessation resource line, providing a range of services for anyone who wants to quit. The goal of such a resource line would be to help increase use of cessation services well above current levels in order to have a measurable impact on tobacco-use rates. Strategies known to increase the reach of quitlines include heavier advertising, free cessation services, free or low-cost medications, and closer links with health systems and other community services. A quitline super-service would also need to be involved in advising tobacco control media campaigns to help generate more calls and promote more quit attempts among all tobacco users. Sharing of media, perhaps using a common resource such as the federally funded, National Cancer Institute's quitline consortium, could help limit media costs.

A super-service quitline could expand the kinds of products and services it offers and more flexibly meet the needs of tobacco users, businesses, health insurers, and other partners. Some of these new products could include:

- Both phone and printed services in multiple languages.
- Streamlined, proactive referral services with feedback mechanisms for health care providers and other health professionals.
- Information and materials supplied to health care providers to support office-based advice, counseling, and referral.

- A referral source for community-based and health plan cessation services that uses data bases about insurance coverage and direct-transfer technology.
- Possible increase of cessation services through web-based programs as the evidence-base for these programs becomes more established.
- Over-the-counter medications by mail order or voucher, integrated with phone counseling.
- Discounts on bulk purchase of medications with prescription medications handled by links with physicians and pharmacies.
- Services tailored to pregnant women and young people.
- Consulting services for health plans, employers, health care providers, and community agencies on tobacco dependence use and treatment.
- A resource on cessation issues for media inquiries.

CASE STUDIES

ARIZONA SMOKERS' HELPLINE

Year founded: 1995
Number of calls in most recent year: 6665 in 2002
Helpline reach (estimated % of tobacco users reached annually): 0.86%
Helpline administration: The Network for Information and Counseling (NICNET) manages the Arizona Smokers' Helpline at the Mel and Enid Zuckerman Arizona College of Public Health. The Helpline is funded by the state's tobacco tax and is administered through the Tobacco Education and Prevention Program of the Arizona Department of Health Services.

How is the Helpline promoted?

The Arizona Smokers' Helpline is promoted through targeted outreach to strategic partners (health care organizations, insurance companies, worksites, community based tobacco control projects, etc.) and mass media campaigns. When television advertising is available, those efforts generate most of the calls. When paid advertising is not available, Helpline clients hear about the services from a wide variety of sources, including referrals from healthcare providers and personal referrals from friends and family.

What happens when someone calls?

The Helpline provides services for tobacco users calling for information for themselves or for counseling assistance and non-tobacco users calling for information for family or friends . Helpline callers receive three options: speak to a counselor, listen to recorded tips, or download faxed copies of cessation management fact sheets. Callers who opt to speak to a counselor can receive a one-time counseling session, enroll in a 12 week proactive telephone counseling program, or be referred to a group-based program in the community. Tobacco users who enroll in a telephone counseling program are called within two days of their quit date and weekly thereafter until the end of the program. Callers providing their name and address are mailed tailored information and the Arizona Smokers' Helpline Guide to a Tobacco-Free Life.

How does the Helpline integrate with health systems?

The Arizona Smokers' Helpline and the HealthCare Partnership Continuing Education and Training Unit are both funded through the Arizona Department of Health Services Tobacco Education and Prevention Program (TEPP). They collaborate with county health departments, health care institutions and providers, and health insurance companies on a fax referral system and a cessation training program. The Helpline and the HealthCare Partnership teach providers skills for delivering brief cessation intervention and using the client referral system.

The HealthCare Partnership Unit also sponsors a Speakers' Bureau for training and continuing education for health care professionals. Once trained, health care professionals are encouraged to ask patients about their tobacco use and gain HIPAA approved written consent from tobacco users for a fax referral to the Helpline. The provider faxes the referral to the Helpline's toll-free fax and a confirmation fax is sent back. Within 48 hours, a Helpline counselor calls the patient, explains the options for services, and enrolls them in the service of their choice. The Helpline then reports the outcome of the referral back to the health care provider (i.e., reached and accepted services, reached and declined services, or not reached).

Who coordinates partnerships?

TEPP, administers the contract for cessation services provided by the University of Arizona. TEPP, through the Helpline, leads outreach to health care systems. TEPP, the Helpline and, the Healthcare Partnership do outreach to clinics/providers to increase referrals into tobacco cessation programs. Multiple managed care organizations and a few major hospitals are collaborating with the Helpline and TEPP to increase access to cessation services.

Are there any additional plans for more integration in the future?

TEPP and its partners will continue to identify new partnerships to help achieve cessation goals with statewide impact.

Are there any other plans for expanding/improving the Helpline?

In 2002-2003, a comprehensive statewide cessation evaluation system, developed by NICNET, was implemented. Improvements to overall cessation in Arizona will be phased in and include multiple levels of evaluation, online distributed data entry by Local Projects, and a sophisticated counseling system. In addition, plans are underway to enhance Internet-based cessation through www.ashline.org

Contact

Pamela Powers, MPH
Program Director, Network for Information and Counseling
Mel and Enid Zuckerman Arizona College of Public Health
pjp@u.arizona.edu
http://www.TEPP.org
http://www.ASHLINE.org

CALIFORNIA SMOKERS' HELPLINE

Year founded: 1992
Number of calls in most recent year 56,941 in 2002
Helpline reach (estimated % of tobacco users reached annually) About 2 percent
Helpline administration: The Helpline is funded by the California Department of Health Services, Tobacco Control Section, with revenue from the 1988 tobacco tax increase and from the California Children and Families Commission. The Helpline is operated by the University of California San Diego, School of Medicine, Department of Family and Preventive Medicine.

How is the Helpline promoted?

California advertises the Helpline through television, radio, billboards, bus signs and local newspapers. Additionally, Helpline staff cultivate partnerships with organizations that are in a position to refer tobacco users to the Helpline. Through direct mailings of promotional packets to providers, educators, and others who interact with tobacco users, partnered mailings to members of professional associations, and other outreach activities, the Helpline continually develops a growing roster of professionals who actively make referrals.

What happens when someone calls?

An intake specialist explains Helpline services and records the caller's choices. All callers receive a list of tobacco cessation services in their county and materials appropriate to their level of readiness to quit. Depending on call volume, clients who choose counseling are either transferred to a counselor for immediate counseling or scheduled for a call-back. All subsequent follow-up sessions are initiated by the counselor, following experimentally validated protocols. The Helpline has separate lines for callers in English, Spanish, Mandarin, Cantonese, Korean, and Vietnamese. It also has a TDD line, a Chew Line, and offers specialized services for teens and pregnant smokers.

How does the Helpline integrate with health systems?

The Helpline reaches out to health care providers to show how tobacco cessation counseling services can help their patients quit and encouraging them to refer their patients. Providers who refer patients receive thank-you letters from the Helpline when the patient calls. Callers who receive counseling and who are covered by the California Medicaid program receive certificates of participation with which they can obtain nicotine replacement therapy or Zyban. Some private health plans such as Kaiser Permanente of Northern California also cover medication for members enrolled in the Helpline's counseling program.

Who coordinates partnerships?

California's tobacco cessation services are largely funded from tobacco tax revenues. The California Department of Health Services administers the program through the Tobacco Control Section, which funds Helpline services for most callers. The California Children and Families Commission also funds a portion of services. Cessation medications are reimbursed through the Medicaid program and some additional California health plans. The DHS-funded Helpline and local projects are responsible for outreach to health care providers and coordinating partnerships. The Next Generation California Tobacco Control Alliance, through its Managed Care Working Group, coordinates partnerships with health plans and purchasers around policy issues, including the expansion of cessation benefits.

Are there any additional plans for more integration in the future?

The Helpline is researching methods for providers to directly enroll pregnant patients in the Helpline services and receive proactive counseling. The decision to expand this service is based on data showing a ten-fold increase in the use of Helpline counseling services when pregnant smokers were proactively enrolled in Helpline services.

Are there any other future plans for expanding/improving the Helpline?

The Helpline continues to develop counseling protocols for special populations such as pregnant and adolescent smokers and Asian-language speakers. These protocols are first tested in large, randomized controlled trials before they are included as a regular Helpline service. The Helpline also continues to develop specialized materials such as language-specific tobacco cessation booklets and tailored mailings.

Contact:
Christopher Anderson
Program Director, California Smokers' Helpline
University of California, San Diego
cmanderson@ucsd.edu
http://www.nobutts.org
(858) 300-1032

MINNESOTA'S TOBACCO HELPLINE

Year founded: 2001.
Number of callers in most recent year: 15,784 from February 2002 – January 2003
Helpline reach (estimated % of tobacco users reached annually): about 2.0 percent of adult smokers.
Helpline administration: Minnesota's Tobacco Helpline is operated by a non-profit organization called the Minnesota Partnership for Action Against Tobacco (MPAAT) with funds from the settlement of Minnesota's case against the tobacco industry. Helpline services are provided through Group Health Cooperative's Center for Health Promotion in Seattle, WA.

How is the Helpline promoted?

Minnesota's Tobacco Helpline is promoted through a combination of paid media, promotion, and public events. Paid media includes a $3 million advertising campaign that uses television, radio, and print. Additionally, promotional items are distributed throughout the state.

Examples of Helpline promotion occurred at the time of launch. At that time MPAAT distributed a media kit followed by two different toolkits in the fall. One toolkit went to groups working on secondhand smoke policy issues and one to clinics and businesses. Public events have included promoting the Helpline at the state fair and sporting events, often handing out promotional water bottles.

The Helpline and MPAAT also received earned media when the Helpline began providing nicotine gum and patches for all callers starting in September 2002. The Helpline did not use any paid advertising to promote the NRT program. Demand for Helpline services increased dramatically with the free nicotine gum and patches, despite the very limited promotion.

What happens when someone calls?

Helpline callers are first asked if they've called before. If yes, their record is located in the database. If no, the screener collects basic information, asks about insurance coverage, and provides information about the Helpline's services.

If an insured caller's health plan offers telephone counseling, the caller is transferred directly to that plan's tobacco quitline. The Helpline works in partnership with seven state health plans to facilitate this triage system.

The Helpline offers uninsured callers, callers who do not have access to telephone counseling through their health plan, and callers who do not wish to be transferred to their health plan's service, the opportunity to speak to a specialist. The specialist asks if the caller is interested in enrolling in Free & Clear, a four-call proactive counseling program. If interested and eligible, the caller can receive patches or gum by mail. Beginning in August 2003, callers interested in counseling will be enrolled directly into the Free & Clear program.

How does the Helpline integrate with health systems?

MPAAT works in partnership with Minnesota's seven largest health plans. These seven plans, covering approximately 95% of Minnesota residents, provide telephone counseling. The Helpline helps promote these quitlines by transferring members who call in. Three of these plans also contract with the Free & Clear

program. Prior to the launch of the Helpline, MPAAT was successful in persuading several plans to provide telephone counseling for their members or eliminate their co-payments.

When the Helpline began providing medications, the number of callers transferred to their health plans declined. MPAAT is working to improve the triage system to help increase transfers again in order to use its resources for the uninsured and those insured without cessation coverage.

MPAAT staff representatives meet quarterly with representatives of the participating health plans to review enrollment data, evaluation, and about services. Between quarterly meetings, MPAAT and the health plans exchange information by electronic mail in order to stay up-to-date on Helpline activities.

Who coordinates partnerships?

The Helpline is administered through the Minnesota Partnership for Action Against Tobacco. MPAAT focuses its programs on adult tobacco users.

Health plans and programs that have partnerships with Minnesota's Tobacco Helpline include: Blue Cross and Blue Shield of Minnesota, HealthPartners, Mayo Clinic, Medica, Metropolitan Health Plan, PreferredOne, and UCare Minnesota.

Contact:
Ann Welding, MD, MPH
Director of Intervention Programs
Minnesota Partnership for Action Against Tobacco
590 Park St. Suite 400
St. Paul, MN. 55103
651-312-3902
awelding@mpaat.org;
http://www.mpaat.org

MASSACHUSETTS TRY-TO-STOP TOBACCO RESOURCE CENTER (INCLUDES TOBACCO-FREE HELPLINE)

Year founded: Massachusetts Smoker's Quitline in 1994; Try-To-STOP TOBACCO Resource Center, which includes the Tobacco-Free Helpline, in 2001.
Number of calls in most recent year: Approximately 6,000 in 2003. (During Fiscal Years 2002 and 2003, there have been no mass media campaigns or statewide quitline promotion in Massachusetts.)
Helpline reach (estimated % of tobacco users reached annually): Historically (1995-1999) the Smokers Quitline reach has been about 1.5% annually. In 2002, the Resource Center and 85 community based tobacco treatment programs, funded by the Massachusetts Tobacco Control Program, reached an estimated 7.5% of adult smokers, providing 56,766 brief interventions and 72,000 intensive counseling sessions.
Helpline administration: The Massachusetts Department of Public Health, Tobacco Control Program funds the Tobacco-Free Helpline and Resource Center and contracts with JSI Research and Training Institute, Inc. to operate the Center. The Resource Center also contracts for services with the states of Rhode Island and New Hampshire.

How are the Helpline and Resource Center promoted?

About 50% of outbound calls are in response to referrals through the QuitWorks project generated by health plan promotions; 25% are inbound calls from smokers referred by a health care professional; 25% of calls are generated by community based program promotions, word-of-mouth referrals, and spillover from Try To STOP media campaigns in adjacent states.

What happens when someone calls?

The Tobacco-Free Helpline offers services to four groups: the general public, including smokers and their families; professionals seeking information; health plan subscribers and providers participating under customized services agreements with eight health plans; and local MTCP-funded community based programs.

For tobacco users, the Helpline is a gateway to multiple options including telephone-based counseling, self-help materials, an interactive, tailored website for smokers, and referral to community based programs that offers counseling and medications.

Telephone counseling for smokers includes an intake, assessment and brief motivational session together with mailed or web-based self-help materials. Tobacco users who are ready to set a quit date within the next 30 days may be transferred to the American Cancer Society Quitline for an intensive counseling program that includes five sessions.

The Helpline is answered live 48 hours per week. Callers waiting on line can leave a voicemail message for an immediate call-back. Voice messages left during off-hours are returned the following business day.

What services are offered through the Resource Center?

The Resource Center has four interconnected services: The Tobacco-Free Helpline (see above); the *trytostop.org* website provides tobacco information, stop-smoking assistance via the self-paced Quit Wizard, a bulletin board facilitated by Quit Experts, and related links; the QuitWorks program; and the Tobacco Education Clearinghouse (MTEC) offering low-cost tobacco education materials (pamphlets, posters, etc.) and providing technical assistance on tobacco education and materials development to Massachusetts's health care professionals, educators, and tobacco control advocates. (The capacity of the MTEC has been reduced due to recent budget cuts)

How does the Helpline integrate with health systems?

The Helpline integrates with health systems through QuitWorks. The QuitWorks program is a collaboration of the Massachusetts Department of Public health and eight commercial and Medicaid health plans. The program offers a referral and enrollment process by which health care providers may enroll any patient for proactive treatment regardless of health insurance coverage. Once contacted, enrollees are offered the full range of the Try-To-STOP TOBACCO Resource Center's services. Referring providers receive immediate and six-month patient status reports.

QuitWorks provides health care providers a simple approach to identifying tobacco users, engaging in a brief intervention, and linking patients to the state's full range of evidence-based tobacco treatment resources. All physicians in Massachusetts have access to the QuitWorks Office Practice Implementation Kit. Kits have been delivered to hospitals, managed care organizations, and physicians' offices throughout the state by more than 100 provider representatives from the participating health plans. QuitWorks kits can be ordered from the Helpline and all materials are available at http://www.quitworks.org.

Who coordinates partnerships?

The Massachusetts Department of Public Health initiates and coordinates partnerships, including those with health plans and health care systems. Service contracts are executed through the Try-To-STOP TOBACCO Resource Center, with Department approval.

Are there any additional plans for more integration in the future?

Several task groups are adapting QuitWorks for specialty practices: OBGYN's, pediatricians, dentists, and disease management case managers. QuitWorks has recently been adopted by hospitals for both inpatient and outpatient units. An institutional task group has convened to customize QuitWorks for additional hospital adopters.

Any other future plans for expanding/improving the Helpline and Resource Center?

Under present budget constraints in Massachusetts, there are no plans to expand the Resource Center services. However, service quality is monitored continuously and improvements are made based on feedback from QuitWorks patients, institutional users, and Helpline website clients.

Contact:
Donna Warner, MBA, MA
Massachusetts Department of Public Health
Tobacco Control Program
250 Washington Street, 4th Floor
Boston, MA 02108
(617) 624-5900 (phone)
(617) 624-5921 (fax)

UTAH TOBACCO QUIT LINE

Year founded: Teen guideline in fall, 2000. Expanded to adults in fall 2001.
Number of calls in most recent year: 13,743 from July 2002 through May 2003
Quit Line reach (estimated % of tobacco users reached annually): about 2.6%
Quit Line administration: The Quit Line is administered through the Utah Department of Health. Quit Line services are provided by Group Health Cooperative's Center for Health Promotion in Seattle, WA.

How is the Quit Line promoted?

The Utah Department of Health contracts with in-state advertising agencies to conduct a media campaign promoting the Quit Line using television, radio, and outdoor advertising. Ads are targeted to high-risk youth, adults, and pregnant women.

What happens when someone calls?

Callers are first asked how they heard about the Quit Line and whether they have called in before. If yes, their record is pulled from the database and their present needs assessed. Usually previous callers are either sent a quit kit or connected to a counseling specialist.

For new callers, the registrar conducts an intake visit, asks adults about health insurance, and provides basic information about the Quit Line's services. Callers covered by Intermountain Health Care (IHC) are transferred directly to Free & Clear. IHC provides Free & Clear services to all members. The Quit Line transfers other callers, covered by a major health plan that offers smoking cessation services, directly to their health plan. Callers who are uninsured, covered by a smaller health plan, or on Medicaid or Medicare are offered a 40-minute counseling session. If interested, these callers are also offered an additional four-call counseling program (Free & Clear) and either nicotine patches or gum. Teens are not screened for insurance and may enroll in a four-call proactive counseling program tailored for teens. No nicotine patches or gum are offered to teens.

How does the Quit Line integrate with health systems?

The Utah Department of Health's Quit Line strongly encourages the major Utah health plans to offer comprehensive cessation counseling and medications. The largest health plans in the state are Cigna, Altius, Blue Cross, Intermountain Health Care, and Molina. Intermountain covers approximately 50% of all Utah residents.

The Quit Line provides direct transfer to other health plans if the plans have a structured cessation program. This can be complex, since there can be variations in coverage even within the same health plan and same employer group. For example, Quit Line callers from the Public Employee Health Plan (PEHP) are transferred to the PEHP program, but will only receive the PEHP smoking cessation benefit if their employer has purchased the Healthy Utah benefit as part of their PEHP package. The Quit Line registrars screen for this coverage and keep an up-to-date list of eligible benefit plans.

Based on results of the Year 1 Evaluation Survey, about one-fourth of the callers who used health plan cessation services reported that they were satisfied with the Quit Line registration service and/or with their health plan's cessation benefit. This compares with much higher satisfaction among callers who were not transferred to their health plan. Only 22% of referred respondents reported that their health plan's cessation service was helpful and 78% reported that Quit Line services were helpful. In the Year 1 evaluation, 41.4% of respondents were uninsured and 57.9% were insured.

Who coordinates partnerships?

The Utah Department of Health, Tobacco Prevention and Control Program is responsible for coordinating partnerships.

Are there any additional plans for more integration in the future?

The State of Utah recently expanded the definition of those who can receive comprehensive services through the Quit Line. Now, callers who are uninsured and on Medicaid together with those who are in the "other insured" category — including Medicare, or covered by one of Utah's smaller health plans — are now eligible for an in-depth, 40-minute counseling session, followed by a four-call counseling program. The state tobacco program pays for medication for these callers.

Any other future plans for expanding/improving the Quit Line?

The Utah Department of Health is now planning to promote the Quit Line more intensively to multicultural populations, particularly to those who speak Spanish. Also, the Department of Health recently developed web-based cessation services, linked closely with the Quit Line at http://utahquitnet.com

Contact:
Jenna Perego, MS
Health Program Specialist
Utah Department of Health
PO Box 142106
Salt Lake City, Utah 84114-2166
jperego@utah.gov
801-538-9283

WISCONSIN TOBACCO QUIT LINE

Year founded: May 2001
Number of calls in most recent year: From January 1 to December 31, 2002: 11,669 calls
Quit Line reach (estimated % of tobacco users reached annually): Approximately 3.3%
Quit Line administration: The Wisconsin Tobacco Quit Line (WTQL) is administered by the Center for Tobacco Research Institute (UW - CTRI) at the University of Wisconsin. Quit Line services are provided by the Center for Health Promotion in Seattle, WA

How is the Quit Line promoted?

Through paid and earned media in both local and statewide venues, the Wisconsin Tobacco Quit Line is promoted as part of Wisconsin's comprehensive tobacco control program. Examples of earned media include the numerous articles in newspapers such as the "McFarland Community Life" or the "Milwaukee Journal Sentinel" describing the Quit Line or programs such as the 2002 Senior Patch Program which offered free nicotine patches to senior citizens in conjunction with the telephone counseling.

A vital component to the promotion of the WTQL are the Regional Outreach Specialists who work throughout the state with healthcare providers, clinics, and systems to implement cessation into their practices using brief interventions which includes referrals to the WTQL. Armed with brochures, bookmarks, and informational business cards designed for smokers who want to quit, the Regional Outreach Specialists disseminate Quit Line materials and fact sheets to clinics as well as public locations. The promotional and outreach programs successfully increased referrals to the Quit Line from health providers from 3.5% of callers in 2001 to almost 16% in 2002.

Upon calling, each person is asked for his or her demographic information as well as insurance information. The Quit Line Specialist provides information regarding the specific Quit Line services and shares information regarding local county-specific cessation resources available to the caller. The State of Wisconsin does not provide nicotine replacement therapy such as the nicotine gum or patch. However, the Quit Line maintains a health plan database for referrals and as a resource on cessation coverage. Callers who have health insurance are given information regarding possible cessation benefit coverage. All callers are sent cessation support materials, fact sheets, and local cessation resources through the Wisconsin Tobacco Quit Kit. Callers who call the Quit Line after hours can leave a voicemail message and are contacted within one business day.

Motivated callers who plan to quit within 30 days but are not ready to set a quit date are offered a 40-minute individualized telephone counseling session. Callers who set a quit date within 30 days are offered the same counseling session and one additional follow-up call around the time of the quit date. Callers who set quit dates greater than 30 days away are offered the counseling session as well as four additional follow-up calls. Callers who have already quit or are in the process of quitting are offered the four follow-up calls. The Quit Line also offers specialized services for pregnant smokers.

How does the Quit Line integrate with health systems?

Each Quit Line Specialist can reference the database of Wisconsin health plans and provide each caller with information regarding cessation coverage and benefits. The Quit Line also offers information and consultation for health care providers, who make up 2-5 percent of callers.

The Regional Outreach Specialists, who are housed in regional Department of Public Health offices, primarily focus on incorporating cessation services into health systems and clinical practices. Outreach activities have included Grand Rounds Trainings, clinic-by-clinic trainings, promoting the Quit Line to all primary care providers, physician assistants, and nurse practitioners, informing providers of reimbursement details of coverage for Medicaid recipients and assisting in the process for provider reimbursement through many of the health plans. CTRI also offers a free, web-based continuing medical education (CME) program for health providers on *Treating Tobacco Use and Dependence - The Clinical Practice Guideline.* UW-CTRI coordinates a provider referral program to the Quit Line, in which providers identify patients interested in quitting and fax referrals to the Quit Line. The Quit Line pro-actively calls the patient and offers enrollment in the counseling programs. Approximately 50 clinics are participating in the program as of the first quarter of 2003

Who coordinates partnerships?

UW-CTRI has a number of partnerships with a variety of organizations from insurers to community-based clinics to pharmaceutical companies.

The Senior Patch Program is an example of how UW-CTRI can partner with the WI Tobacco Quit Line and several organizations. GlaxoSmithKline made a generous donation of nicotine patches that UW-CTRI was able to distribute to a number of community clinics serving Wisconsin's elder population.

UW-CTRIs has partnered with Aurora Health Systems, one of Wisconsin's largest health plans and employers. UW-CTRI and Aurora piloted a program to bring provider education to a region of Wisconsin, testing to see if provider education would increase referrals to the Quit Line and subsequent quit attempts. Building on the success of the pilot, Aurora expanded the program to Milwaukee, included Quit Line information on their website, and are using UW-CTRI materials as well as developed additional materials with input from UW-CTRI staff.

Are there any additional plans for more integration in the future?

UW-CTRI is starting a new partnership with the Primary Healthcare Network Association (PHNA) to reach underserved populations and provide free nicotine patches and counseling. The PHNA is a network of federally funded primary care clinics in medically underserved areas of the Wisconsin. Through this partnership, UW- CTRI will reach close to 3,000 uninsured and underinsured tobacco users with the resources to quit.

Are there any other future plans for expanding/improving the Quit Line?

UW-CTRI plans to expand its reach and improve access to cessation resources by establishing a fax-referral program at worksites, based on the clinic system, hiring a staff person who can work more systematically with health plan administrators, and hire a communications expert to work on Quit Line promotions, particularly targeting multicultural populations.

Contact:
Lezli Redmond, MPH
Director of Education and Outreach Programs
Center for Tobacco Research and Intervention
University of Wisconsin Medical School
1930 Monroe Street
Madison, WI 53711
(608) 265-4143
lr3@ctri.medicine.wisc.edu

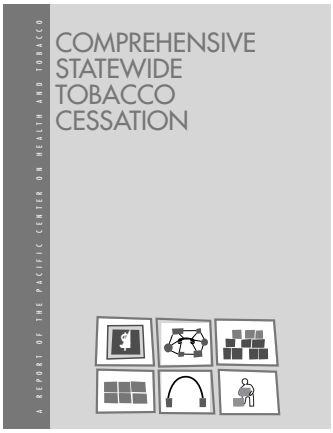
REFERENCES

1. Centers for Disease Control and Prevention. *Best practices for comprehensive tobacco control programs – August 1999*. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, August 1999. Reprinted with corrections. www.cdc.gov/tobacco/bestprac.htm
2. Fiore MC, Bailey WC, Cohen SJ, et al. *Treating Tobacco Use and Dependence*. Clinical Practice Guideline. Rockville, MD: U.S. Department of Health and Human Services, Public Health Service. June 2000. www.surgeongeneral.gov/tobacco
3. Centers for Disease Control and Prevention. Strategies for reducing exposure to environmental tobacco smoke, increasing tobacco-use cessation, and reducing initiation in communities and health-care systems: A report on recommendations of the Task Force on Community Preventive Services—United States 2000. *Morbidity and Mortality Weekly Report* 2000; 49(RR12): 1-11. www.cdc.gov/tobacco/comguide.htm
4. Coffield AB, Maciosek MV, MCGinnis MJ, et al. Priorities among recommended clinical preventive services. *American Journal of Preventive Medicine* 2001; 21(1).
5. U.S. Department of Health and Human Services. Reducing Tobacco Use: A Report of the Surgeon General. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, Office on Smoking and Health; 1999.
6. National Academy of Sciences, Institute of Medicine, Priority areas for national action: Transforming healthcare quality. January 7, 2003; pg.89.
7. National Cancer Institute. *Population-based smoking cessation: Proceedings of a conference on what works to influence cessation in the general population*. Smoking and Tobacco Control Monograph No. 12. Bethesda, MD: U.S. Department of Health and Human Services, National Institutes of Health, National Cancer Institute, NIH Pub. No. 00-4892, November 2000.
8. Hopkins DP, Briss PA, Ricard CJ, et al. Reviews of evidence regarding interventions to reduce tobacco use and exposure to environmental tobacco smoke. *American Journal of Preventive Medicine.* 2001;20 (2S):16–66.
9. Lichtenstein E, Glasgow RE, Lando HA, Ossip-Klein DJ, et al. Telephone counseling for smoking cessation: rationales and meta-analytic review of evidence. *Health Education Research: Theory and Practice* 1996;11:243-257.
10. Stead LF, Lancaster T. Telephone counseling for smoking cessation (Cochrane Review). In: The Cochrane Library. 2002; Cochrane Library CD 000214.
11. See www.ctcinfo.org/upload/state_cessation_table.pdf
12. McAfee T, Sofian N, Wilson J, Hindmarsh M. The role of tobacco intervention in population-based health care. *American Journal of Preventive Medicine* 1998; 14: 46-52.
13. Zhu S-H, Anderson CM, Johnson CE, Tedeschi G, Roeseler A. A centralized telephone service for tobacco cessation: The California experience. *Tobacco Control* 2000; 9 (suppl II): ii48-ii55.
14. Zbikowki S, McAfee T, Baker A, Wassum, K. *Oregon Tobacco Quit Line Evaluation Report: Year 4*. Group Health Cooperative, Center for Health Promotion, 2002.
15. Tobacco-Free Coalition of Oregon. Making the Quitting Connection Evaluation Summary, Report to the Oregon Health Plan, December 2002.
16. Powers P. Direct Client Services: *Tobacco Education and Prevention Program FY 01-02 Annual Report*, October 2003.
17. Swartz S., Cowan T. The Maine Tobacco Helpline and Medication Voucher Program: October 2002. Report for the Partnership for Tobacco-Free Maine, Bureau of Health, Department of Human Services. May 2003.

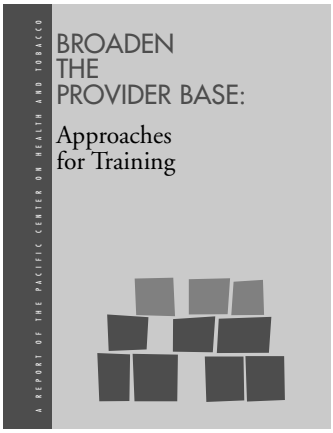
18. Anderson, C. *The role of quitlines in comprehensive tobacco control programs*. Presentation at the Hawaii Trust Fund Advisory Committee Meeting, Honolulu, Hawaii, January 21, 2003.
19. McAfee T, Waking the health plan giant: Group Health Cooperative stops counting sheep and start counting key tobacco indicators. *Tobacco Control* 1998; 7 (suppl): S41-S44.
20. Zhu, S-H. *Survey of quitlines in North America*. Presentation at the North American Conference of Smoking Cessation Quitlines, Phoenix, Arizona, May 8, 2002.
21. Zhu, S-H. *Expanding the role of quitlines in a population-based approach to cessation*. Testimony given at the Interagency Committee on Smoking and Health, Subcommittee on Tobacco Cessation, Denver, Colorado, November 14, 2002.

APPENDIX A:
REPORTS AND RESOURCES

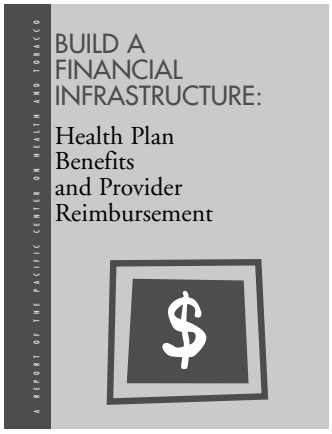
The PCHT has developed a series of reports and resources, available on our website, to help implement a comprehensive statewide tobacco cessation program. Here is a selection:



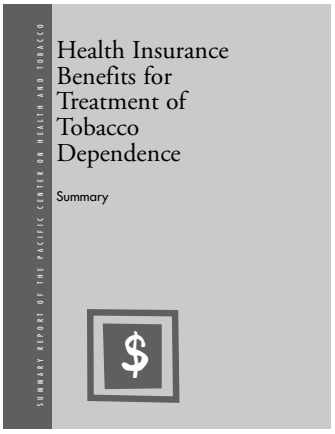
COMPREHENSIVE STATEWIDE TOBACCO CESSATION
The PCHT rationale, vision, model, and strategy for a comprehensive, state-based approach to tobacco cessation.



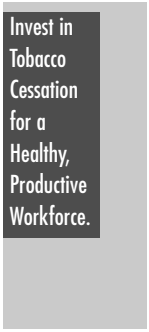
BROADEN THE PROVIDER BASE: Approaches for Training. Outlines the benefits and approaches to provider and specialist training and discusses the pros and cons of certification.



BUILD A FINANCIAL INFRASTRUCTURE: Health Plan Benefits and Provider Reimbursement:
The evidence-base and recommendations for purchasers, health plans and providers to set up and fund tobacco cessation services is outlined.



HEALTH INSURANCE BENEFITS FOR TREATMENT OF TOBACCO DEPENDENCE:
At-a-glance summary from the "Build a Financial Infrastructure." This summary is intended to help guide discussions with employers and purchasers, and can be tailored to each state.



INVEST IN TOBACCO CESSATION FOR A HEALTHY, PRODUCTIVE WORKFORCE:
A brief summary for employers that can be tailored to each state, outlining the business case for tobacco cessation benefits.

Pacific Center on Health and Tobacco

PCHT Website:
www.paccenter.org

Coming up:
BRIDGING GAPS: Outreach to Diverse Groups

APPENDIX B:
CDC/OSH TRAINING AND TECHNICAL ASSISTANCE PROJECT:QUITLINE RESOURCE GUIDE*

The Centers for Disease Control and Prevention's Office on Smoking and Health has developed The Quitline Resource Guide to help states and health care agencies contract for and monitor the operation and evaluation of tobacco cessation quitlines. This guide will also help states and agencies with existing quitlines enhance their services. Because there are few empirical studies on many of the decisions a manager needs to make in contracting for quitline services, the information and recommendations presented are based primarily on the expert opinion of a panel of tobacco control professionals who have experience with quitlines. Where studies exist, they are cited in support of the panel's recommendations.

Topics covered in the Quitline Resource Guide include:

- The role of quitlines in comprehensive tobacco control programs
- Range of practice
- Contracting for quitline services
- Technological considerations
- Staffing a quitline
- Quality assurance in quitline counseling
- Evaluating quitline services
- Costs associated with operating a quitline
- Promoting quitlines
- Developing community partnerships
- Future directions

For more information and to obtain a copy, visit the CDC website at http://www.cdc.gov/tobacco.

*Suggested citation: Centers for Disease Control and Prevention. Quitline Resource Guide: Strategies for Effective Development, Implementation, and Evaluation. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health; 2003.

APPENDIX C:
TOBACCO CONTROL EVIDENCE BASE RECOMMENDATIONS, QUITLINE EVIDENCE BASE, QUITLINE COSTS

TOBACCO CONTROL EVIDENCE BASE RECOMMENDATIONS

Summary of Evidence Base Recommendations Used by the PCHT

Public Health Service's (PHS) Clinical Practice Guideline on Treating Tobacco Use and Dependence

Fiore MC, Bailey WC, Cohen SJ, et al. *Treating Tobacco Use and Dependence*. Clinical Practice Guideline. Rockville, MD: U.S. Department of Health and Human Services, Public Health Service. June 2000.

The PHS clinical practice guideline makes the following recommendations:

1. Tobacco dependence is a chronic condition that often requires repeated intervention. However, effective treatments exist that can produce long-term or even permanent abstinence.

2. Because effective tobacco dependence treatments are available, every patient who uses tobacco should be offered at least one of these treatments:
    a. Patients *willing* to try to quit tobacco use should be provided with treatments identified as effective.
    b. Patients *unwilling* to try to quit tobacco use should be provided with a brief intervention designed to increase their motivation to quit.

3. It is essential that clinicians and health care delivery systems (including administrators, insurers, and purchasers) institutionalize the consistent identification, documentation, and treatment of every tobacco user seen in a health care setting.

4. Brief tobacco dependence treatment is effective, and every patient who uses tobacco should be offered at least brief treatment.

5. There is a strong dose-response relationship between the intensity of tobacco dependence counseling and its effectiveness. Treatments involving person-to-person contact (via individual, group, or proactive telephone counseling) are consistently effective, and their effectiveness increases with treatment intensity (e.g., minutes of contact).

6. Three types of counseling and behavioral therapies were found to be especially effective and should be used with all patients attempting tobacco cessation:
    a. Provision of practical counseling (problem solving/skills training);
    b. Provision of social support as part of treatment (intra-treatment social support); and
    c. Help in securing social support outside of treatment (extra-treatment social support).

7. Numerous effective pharmacotherapies for smoking cessation now exist. Except in the presence of contraindications, these should be used with all patients attempting to quit smoking.
    a. Six first-line pharmacotherapies were identified that reliably increase long-term smoking abstinence rates:
        i. Bupropion SR
        ii. Nicotine gum
        iii. Nicotine inhaler
        iv. Nicotine nasal spray
        v. Nicotine patch
        vi. Nicotine lozenge

b. Two second-line pharmacotherapies were identified as efficacious and may be considered by clinicians if first-line pharmacotherapies are not effective:
    i. Clonidine
    ii. Nortriptyline
c. Over-the-counter nicotine patches are effective relative to placebo, and their use should be encouraged.

8. Tobacco dependence treatments are both clinically effective and cost-effective relative to other medical and disease prevention interventions. As such, insurers and purchasers should ensure that:
    a. All insurance plans include as a reimbursed benefit the counseling and pharmacotherapeutic treatments identified as effective in this guideline.
    b. Clinicians are reimbursed for providing tobacco dependence treatment just as they are reimbursed for treating other chronic conditions.

The "5 A's"

The PHS guideline summarizes the clinical implementation of treatment for tobacco dependence as the "5 A's":

ASK	about tobacco use; i.e., identify and document tobacco use status for every patient at every visit.
ADVISE	to quit; i.e., using a clear, strong and personalized manner, urge every tobacco user to quit.
ASSESS	willingness to make a quit attempt; i.e., ask if the tobacco user is willing to make a quit attempt at this time.
ASSIST	in quit attempt; i.e., for patients willing to make a quit attempt, use counseling and pharmacotherapy to help them do so.
ARRANGE	follow-up; i.e., schedule follow-up contact, preferably within the first week after the quit date.

Community Preventive Service Guidelines

Centers for Disease Control and Prevention. Strategies for reducing exposure to environmental tobacco smoke, increasing tobacco-use cessation, and reducing initiation in communities and health-care systems: A report on recommendations of the Task Force on Community Preventive Services—United States 2000. *Morbidity and Mortality Weekly Report* 2000; 49(RR12): 1-11.

The following are strategies recommended for health care systems by the Community Preventive Services Task Force, 2000:

1. Multicomponent tobacco-use cessation interventions that include telephone support.
2. Health care systems are strongly recommended to provide multi-component tobacco-use cessation interventions that include provider reminder systems plus provider education programs with or without patient education.
3. Health care systems are recommended to reduce patient out-of-pocket costs for effective cessation therapies.
4. Increase the unit price of tobacco products.
5. Mass media education campaigns to increase tobacco-use cessation.

CDC Best Practices Document

Centers for Disease Control and Prevention. *Best practices for comprehensive tobacco control programs – August 1999.* Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, August 1999. Reprinted with corrections.

The following are the CDC's best practice recommendations for states:

1. Establish population-based counseling and treatment programs, such as cessation helplines.
2. Make the system changes recommended by the PHS cessation guidelines.
3. Cover treatment for tobacco use under both public and private insurance.
4. Eliminate cost barriers to treatment for under-served populations, particularly the uninsured.

Summary: Priorities Among Recommended Clinical Preventive Services

Coffield AB, Maciosek MV, McGinnis MJ, et al. Priorities among recommended clinical preventive services. *American Journal of Preventive Medicine* 2001; 21(1).

Assessing adults for tobacco use and providing tobacco cessation counseling is second in priority only to vaccinating children as a prevention service with a high proportion of potential disease and injury prevention at high cost-effectiveness. Assessing adolescents for tobacco use and providing an anti-tobacco message or advice to quit is the fifth priority.

Both assessing adults for tobacco use and providing cessation counseling and assessing adolescents for tobacco use and providing an anti-tobacco message or advice to quit are high priority preventive services with less than 50% delivery rate. Both of these preventive services are high-priority opportunities for improving health and reducing costs.

QUITLINE EVIDENCE BASE

The Efficacy of Quitlines and their Role in Comprehensive Tobacco Control Programs

*(Excerpted from the CDC's **Quitline Resource Guide**)*

Overview

Tobacco use continues to be the leading cause of death and disease in the United States. Over 440,000 people in the U.S. die of tobacco-related diseases each year (MMWR, 2002). Cessation of tobacco use, however, can reverse many adverse health effects, even for those who have used it for many years (USDHHS, 1990; USDHHS, 1999). It also saves money; tobacco use is estimated to cost the nation over $75 billion annually in excess medical expenses and $81.9 billion in lost productivity (MMWR, 2002).

Cessation rates, however, have been low. One recent national survey indicates that only 4.1 percent of smokers quit annually (CDC, 2002b) and only about 2.5% of smokers quit smoking permanently each year (CDC, 1999). The low rate is due in part to the fact that half of smokers do not even make a quit attempt in any given year. But it is also because most people who try to quit smoking relapse soon afterward (USDHS, 1990; USDHSS, 1999).

Therefore, an increase either in the proportion of smokers making quit attempts or in the success rate of their attempts will lead to an increase in the overall cessation rate (Burns et al., 2000). Most cessation programs have focused on providing effective aids to smokers who are attempting to quit and who seek help to do so. The task of increasing assisted quit attempts in the general smoking population seems outside of their scope of work. A comprehensive tobacco control program, however, is concerned with the overall cessation rate, not just the cessation rate of those who seek help to quit. From this perspective, an ideal cessation program would not only provide effective service for those who are attempting to quit, but would also help promote assisted quit attempts in the general smoking population.

Telephone quitlines have emerged as just such a cessation program. Their effectiveness with smokers who call them has been well established (Fiore et al., 2000; Hopkins et al., 2001, Lichtenstein et al., 1996; Stead & Lancaster, 2002, Zhu et al., 2002). Moreover, they have been used regularly to promote quit attempts. In many states where there is a comprehensive tobacco control program, quitlines have become an integral part of media messages aiming to increase quit attempts in the general smoking population. In fact, the potential of quitlines to have a meaningful impact on statewide cessation rates has already led 33 states in the U.S. to establish quitlines (Bailey et al., 2003). The following will briefly review why quitlines are well suited to lead the cessation effort in comprehensive tobacco control programs.

Effectiveness of Quitlines

A service program must first demonstrate its effectiveness before it can be promoted. Several meta-analytical reviews have established that telephone-based interventions have done that, and that they are known to be effective in helping smokers quit (Fiore et al., 2000; Hopkins et al., 2001; Lichtenstein et al., 1996; Stead & Lancaster, 2002). The evidence is strongest for proactive counseling, in which the quitline initiates counseling sessions with smokers' prior consent. The current U.S. Public Health Service's Clinical Practice Guideline, *Treating Tobacco Use and Dependence* and the *Guide to Community Preventive Services* both recommend proactive telephone counseling as an effective method to help smokers quit (Fiore et al., 2000; Hopkins et al., 2001).

There is also evidence that reactive quitlines can be effective (Ossip-Klein et al., 1991), although it is less conclusive than the evidence for proactive quitlines (Stead & Lancaster, 2002). In a typical reactive quitline study, only a minority of smokers assigned to the quitline condition calls and receives a one-time brief conversation with quitline staff.

An explanation of the effectiveness of reactive quitlines is that knowledge of the quitline, and the promotion associated with it, increase smokers' beliefs both about the normalcy of quitting and about their own ability to do it (Wakefield & Borland, 2000; Zhu, 2000). This may lead to increased quit attempts among smokers who know about the quitline, including those who do not call. If quit attempts are increased by having a quitline promoted in a given population, as has indeed been demonstrated (Ossip-Klein et al., 1991), then some of the additional quit attempts may lead to permanent success even among smokers who do not use the quitline. This is the implicit assumption underlying most reactive quitlines that spend significantly more money on promotion than on operations.

Synergy with Other Elements of a Comprehensive Tobacco Control Program

A comprehensive tobacco control program typically consists of four major elements: (1) preventing initiation, (2) increasing cessation, (3) eliminating second-hand smoke exposure, and (4) identifying and eliminating disparities in tobacco use and its effects among different population groups (CDC, 1999). Quitlines focus on cessation itself, but their media message promoting quitting can dovetail with those of other program activities, such as the campaign against second-hand smoke and the effort to reduce disparities in access to services by smokers of ethnic minority backgrounds.

In the area of cessation, many components of a comprehensive program promote quitting. The media campaign may be the most frequently used channel to promote quitting directly, but there are other channels as well. Mobilizing the healthcare system to increase physician advice to smokers also promotes quitting. Many school projects, while focusing on prevention, also promote quitting among adolescent smokers. At the same time, worksite restrictions on smoking and tax increases on cigarettes also promote quitting, though indirectly (Burns et al., 2000).

A quitline complements all of these activities by sending the message that help to quit is just a phone call away. Thus, a quitline not only provides direct service to smokers who call, it also facilitates the operation of other components in a comprehensive program. Such interactions create a synergy among different components of the program (Burns et al., 2000). A quitline, as a single centralized operation with recognizable branding and telephone numbers that are universal within the state, facilitates cooperation with other components of a comprehensive program, both logistically and economically.

An example of the synergy created between components of a comprehensive tobacco control program can be seen in the collaboration between a state's quitline and media campaign. The media have been used extensively to educate the public about the dangers of smoking, and a common theme of such campaigns is the harmfulness of second-hand smoke (Stevens, 1998). This theme is only indirectly related to cessation, but the two themes can be linked. When the spots are tagged with the quitline number, the messages become more complete in the sense that they not only provide smokers with reasons to quit, but offer help at the same time. Interestingly, in a campaign in California, the tagged second-hand smoke ads outperformed the tagged health ads with respect to number of calls generated. Thus, second-hand smoke ads that without the quitline number would have had a focus only on protecting nonsmokers, became an efficient tool for driving smokers to use a cessation service (Anderson & Zhu, 2000).

Another area for synergy between a quitline and other components of a comprehensive program is in its role of helping to eliminate disparities in access to cessation services for smokers of ethnic minority backgrounds, who collectively are much less likely to use cessation services than Caucasian smokers. Among the many possible reasons for the disparities is, in some cases, a language barrier. It would be cost-prohibitive to ensure that all local cessation programs across a state had multilingual capabilities. It is much more feasible to address such a disparity in a centralized operation, in which separate language lines can be set up to cover the entire state, just as the English line does. A media campaign using actors from the target community and con-

ducted in the target language becomes a campaign not only to promote cessation in that community, but also to encourage its members to access available services, thus helping to address the disparity of access. As evidence of this synergy, data from the California quitline has showed that a culturally and linguistically targeted campaign, tagged with the quitline's number, drew smokers of ethnic minority backgrounds at the same rate as the general market campaign drew Caucasian smokers (Zhu et al., 1995).

The ability of a quitline to synergize with the rest of a comprehensive tobacco control program helps makes it a central force in a state's cessation effort. A survey of existing quitlines indicates that their activities span from serving as a statewide clearinghouse of tobacco education materials to providing specialized service to particular segments of the population, such as pregnant smokers or Vietnamese-speaking smokers. In addition to partnering with media campaigns, quitlines have been used as an add-on to physician advice to quit smoking (McAfee et al., 1998), to help smokers obtain pharmacotherapy (Waa et al., 2001) and to work with the school system to encourage young smokers to quit early. Research will continue to bring forth new results regarding the effectiveness and utility of various quitline services. In the meantime, of course, quitlines across the U.S. are performing their core function of helping thousands of callers quit smoking each year.

QUITLINE COSTS

Summary of Quitline Costs

The CDC Quit Line Resource Guide provides a thorough discussion of the details for operating quitlines, including rationale, costs, and developing a quitline budget. The Quitline Resource Guide can be found at http://www.cdc.gov/tobacco. The following summarizes some of the cost issues discussed by the PCHT.

States interested in developing cessation services most often want to know the cost of quitlines compared to other types of cessation services. In the PCHT approach, quitlines are understood as part of a larger, comprehensive system. The expectation is not that quitlines will be the only resource available, but will serve as an integral part of the larger system. Thus, evaluating the cost/benefit of adding a quitline verses other types of services likely undervalues the broader impact of the quitline.

The quitline also serves callers who are not tobacco users. The California Helpline estimates that 7% are proxy callers, calling on behalf of family or friends (Zhu & Anderson, et al., 2000). In Year 4 of the Oregon Tobacco Quitline, about 90% of all callers were tobacco users with 10% calling for information for himself/herself or a family member or were health care providers (Zbikowki, et al., 2002). Providing services to several types of callers is important in assisting tobacco users to quit.

Quitlines, even the less intensive reactive quitlines, are considered to be important components of statewide tobacco control programs (IOM, 2003) and are often supported in the context of a larger media campaign. A less intensive quitline may be just as effective as a more intensive quitline if the money not spent on counseling is used for more quitline promotion to increase the reach of the quitline, which ultimately promotes quitting in general.

Another consideration is the cost of adding a quitline compared to the cost of providing a range of services across an entire state and the potential reach of each approach. Given the need to widely promote any service in order to reach potential quitters, a convincing argument can be made for the cost efficiency of promoting one centralized service than multiple local services. At the same time, a centralized quitline can serve as an information clearinghouse and provide direct referrals to those programs for callers who want to use them. And in the provision of counseling itself, centralization brings an economy of scale. Since demand for quitline services is largely a function of how much they are promoted, which is itself a controllable factor, it is possible to staff the quitline at a level at which all staff members are efficiently utilized, which is not always the case with smaller local programs which are more vulnerable to fluctuating demand. In fact, the economy of scale may be sufficient to enable the quitline to offer multilingual and other specialized services to users, which would be cost-prohibitive for most local cessation clinics. The economy of scale associated with centralized operation is a main reason that many states consider a quitline to be the first choice in a statewide cessation program: it acts as a safety net for all tobacco users statewide, a consideration that is even more important when states suffer cuts in their cessation budgets.

Another important advantage that quitlines enjoy is their accessibility. A telephone operation eliminates many of the barriers of traditional cessation classes, which can include having to wait for classes to form and the need to arrange for transportation. Quitlines are particularly helpful for those with limited mobility or who live in rural or remote areas. And due to the more private quitline services, they can appeal to those who are reluctant to seek help in a group setting. (Zhu & Anderson 2000). In short, everyone who has access to a telephone—in a state where there is a quitline—has access to the quitline's services. As evidence of the greater accessibility of quitlines, surveys have indicated that smokers are several times more likely to use such a service than they are to use a face-to-face program (McAfee 2002; Zhu & Anderson 2000). Moreover, populations that are under-represented in traditional cessation services, such as smokers of ethnic minority backgrounds, actively seek help from quitlines (Zhu et al., 1995).

Most quitlines combine services, mixing reactive counseling and proactive counseling along with sending out printed materials and other services. The right mixes of services for a state, and therefore the cost estimate for a state, will vary considerably. Developing the right quitline service strategy is an evolving issue even in states with a longer history of running quitlines.

Suggested Citation: Centers for Disease Control and Prevention. Quitline Resource Guide: Strategies for Effective Development, Implementation, and Evaluation. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health; 2003.

QUITLINE REFERENCES

Anderson CM, Zhu S-H. The California smokers' helpline: a case study. Sacramento, CA: California Department of Health and Human Services; May 2000.

Burns DM, Shanks TG, Major JM, Gower KB, Shopland DR, eds. National Cancer Institute. *Population Based Smoking Cessation: Proceedings of a Conference on What Works to Influence Cessation in the General Population.* Smoking and Tobacco Control Monograph No. 12. Bethesda, MD: U.S. Department of Health and Human Services, National Institutes of Health, National Cancer Institute, NIH Publication No.00-4892; 2000:189-197.

Bailey LM, et al. Center for Tobacco Cessation, Fact Sheet: States with Tobacco Quit Lines. Washington D.C., April 2003. Available at www.ctcinfo.org.

Centers for Disease Control and Prevention. Best Practices for Comprehensive Tobacco Control Programs–August 1999. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health; August 1999.

Centers for Disease Control and Prevention. Smoking-Attributable Mortality, Morbidity, and Economic Costs (SAMMEC): Maternal and Child Health (MCH) SAMMEC software, 2002b.

Fiore MC, Bailey WC, Cohen SJ, et al. *Treating Tobacco Use and Dependence*. Clinical Practice Guideline. Rockville (MD): U.S. Department of Health and Human Services; June 2000.

Hopkins DP, Briss PA, Ricard CJ, et al. Reviews of evidence regarding interventions to reduce tobacco use and exposure to environmental tobacco smoke. *American Journal of Preventive Medicine* 2001; 20(2S):16–66.

Lichtenstein E, Glasgow RE, Lando HA, Ossip-Klein DJ, et al. Telephone counseling for smoking cessation: rationales and meta-analytic review of evidence. *Health Education Research: Theory and Practice* 1996; 11:243-257.

McAfee T, Sofian N, Wilson J, Hindmarsh M. The role of tobacco intervention in population-based health care. *American Journal of Preventive Medicine* 1998; 14: 46-52.

McAfee T, poster (unpublished data). Northern American Conference on Smoking Cessation Quitlines, Phoenix, AZ: 2002.

MMWR — Annual Smoking-Attributable Mortality, Years of Potential Life Lost, and Economic Costs — United States, 1995–1999 April 12, 2002 / Vol. 51 / No. 14.

National Academy of Sciences, Institute of Medicine, Priority areas for national action: Transforming health care quality. January 7, 2003; pg.89.

Ossip-Klein DJ, Giovino GA, Megahed N, Black PM, et al. Effects of a Smokers' Hotline: Results of a 10-County Self-Help Trial. Journal of Consulting and Clinical Psychology 1991; 59:325-332.

Stead LF, Lancaster T. Telephone counseling for smoking cessation (Cochrane Review). In: The Cochrane Library. 2002; Cochrane Library CD 000214.

Stevens, C. (1998). Designing an effective counter-advertising campaign--California. *Cancer* 83(12 Suppl), 2736-41.

U.S. Department of Health and Human Services. The Health Benefits of Smoking Cessation. U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control and Prevention, Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 1990.

U.S. Department of Health and Human Services. Reducing Tobacco Use: A Report of the Surgeon General. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, Office on Smoking and Health; 1999.

U.S. Department of Health and Human Services. Reducing the Health Consequences of Smoking: 25 Years of Progress. A Report of the Surgeon General. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control, Office on Smoking and Health; 1989.

Waa, A, Glasgow, H, McCulloch, M. (2001; August). Subsidization of nicotine replacement therapies through the New Zealand Quitline. Paper presented at the 2nd European Quitline Conference. Barcelona, Spain.

Wakefield M, Borland R. Saved by the bell: the role of telephone helpline services in the context of mass-media anti-smoking campaigns. *Tobacco Control* 2000; 9:17–9.

Zbikowki S, McAfee T, Baker A, Wassum, K. *Oregon Tobacco Quit Line Evaluation Report: Year* 4. Group Health Cooperative, Center for Health Promotion, 2002.

Zhu S-H, Anderson CM, Tedeschi GJ, Rosbrook B, et al. Evidence of real-world effectiveness of a telephone quitline for smokers. *New England Journal of Medicine* 2002; 347p(14): 1087-1093.

Zhu S-H, Anderson CM, Johnson CE, Tedeschi G, Roeseler A. A centralized telephone service for tobacco cessation: The California experience. *Tobacco Control* 2000; 9 (suppl II): ii48-ii55.

Zhu S-H, Tedeschi GI, Anderson CM, Rosbrook, et al. Telephone counseling as adjuvant treatment for nicotine replacement therapy in a "real world" setting. *Preventive Medicine* 2000; 31:357-363.

Zhu S-H, Rosbrook B, Anderson CM, et al. The demographics of help-seeking for smoking cessation in California and the role of the California Smoker's Helpline. *Tobacco Control* 1995; 4:S9-15.

APPENDIX D: PCHT MEMBERSHIP

ARIZONA

Bob Leischow, MPH
Arizona Department of Health Services
Tobacco Education and Prevention Program
1740 W. Adams, #203-S
Phoenix, AZ 85007
(602) 364-0845
(602) 364-0844 (fax)
bleisch@hs.state.az.us

Pamela Powers, MPH
University of Arizona Network for Information and Counseling
Arizona's Smokers Helpline
PO Box 210482
Tucson, AZ 85712-0482
(520) 318-7212 x 203
(520) 318-7222 (fax)
pjp@u.arizona.edu

Tim Connolly, RN, MN
University of Arizona
College of Family and Community Medicine
Arizona Health Sciences Center
1450 N. Cherry Avenue.
Tucson, AZ 85719
(520) 626-1084
(520) 626-1080 (fax)
tconnoll@u.arizona.edu

Myra Muramoto, MD, MPH
University of Arizona
College of Family and Community Medicine
Arizona Health Sciences Center
1450 N. Cherry Avenue.
Tucson, AZ 85719
(520) 626-1086
(520) 626-1080 (fax)
myram@u.arizona.edu

CALIFORNIA

Christopher Anderson
California Smokers' Helpline
9500 Gilman Dr. MC 0905
La Jolla CA 92093-0905 USA
(858) 300-1032
(858) 300-1099 (fax)
cmanderson@ucsd.edu

Beau Carter
Integrated Healthcare Association
45 Quail Court, Suite 205
Walnut Creek, CA 94596
(925) 746-5100, ext. 19
(925) 746-5103 (fax)
bcarter@iha.org

Traci Verardo
Next Generation California Tobacco Control Alliance
980 Ninth Street, Suite 370
Sacramento, CA 95814
(916) 554-0390
(916) 554-0399 (fax)
traci.verardo@tobaccofreealliance.org

Larry Dickey, MD, MSW, MPH
Office of Clinical Preventive Medicine
CA Department of Health Services
714 P Street, Rm. 1492
Sacramento, CA 95814
(916) 657-1493
(916) 657-3089 (fax)
ldickey@dhs.ca.gov

HAWAII

Clifford Chang, MPH, CHES
Coalition for a Tobacco Free Hawaii
245 N. Kakui Street, Suite 201
Honolulu, HI 96817
(808) 595-7500 ext. 116
(808) 595-9072 (fax)
cchang@cancer.org

OREGON

Nancy Clarke
Department of Human Services, Health Division
800 NE Oregon Street, #730
Portland, OR 97232
(503) 731-4273
(503) 731-4082 (fax)
nancy.g.clarke@state.or.us

Wendy Bjornson, MPH
Oregon Health Sciences University/
Tobacco-Free Coalition of Oregon
1425 NE Irving, #100
Portland, OR 97232
(503) 236-0361
(503) 872-9336 (fax)
Wendy_Bjornson@qwest.net

Elizabeth Laws, MPA
Oregon Health Sciences University/
Tobacco-Free Coalition of Oregon
1425 NE Irving, #100
Portland, OR 97232
(503) 236-0361
(503) 872-9336 (fax)
Elizabeth_Laws@qwest.net

Jennifer Reeves
Oregon Health Sciences University/
Tobacco-Free Coalition of Oregon
1425 NE Irving, #100
Portland, OR 97232
(503) 236-0361
(503) 872-9336 (fax)
Jennifer_Reeves@qwest.net

Dawn Robbins
Oregon Health Sciences University/
Tobacco-Free Coalition of Oregon
1425 NE Irving, #100
Portland, OR 97232
503-236-0361
503-872-9336
Dawn_Robbins@qwest.net

WASHINGTON

Rachel Grossman
Group Health Cooperative,
Center for Health Promotion
12401 E. Marginal Way S.
Tukwila, WA 98168
(206) 988-7925
(206) 988-7900(fax)
grossman.r@ghc.org

Tim McAfee, MD, MPH
Group Health Cooperative of Puget Sound
Center for Health Promotion
12401 E. Marginal Way S.
Tukwila, WA 98168
(206) 988-7919
(206) 988-7900 (fax)
mcafee.t@ghc.org

Sara Tifft, MBA
Group Health Cooperative,
Center for Health Promotion
4969 N.E. Avalon Lane
Bainbridge, WA 98110
(206) 855-9508
(206) 855-9508 (fax)
stifft@bainbridge.cnchost.com

Ken Wassum
Group Health Cooperative,
Center for Health Promotion
12401 E. Marginal Way S.
Tukwila, WA 98168
(206) 988-7938
(206) 988-7900 (fax)
wassumk@ghc.org

Karen Krueger, RN, MN, MBA
WA State Dept. of Health
Chronic Disease and Reduction Unit
P.O. Box 47855
Olympia, WA 98904-7855
(360) 236-3611
(360) 236-3646 (fax)
karen.krueger@doh.wa.gov

Tamatha Thomas-Haase
WA State Dept. of Health
Chronic Disease and Reduction Unit
P.O. Box 47855
Olympia, WA 98904-7855
(360) 236-3722
(360) 236-3646 (fax)
tamatha.thomas-haase@doh.wa.gov

CENTERS FOR DISEASE CONTROL AND PREVENTION

Corinne Husten, MD, MPH
Centers for Disease Control and Prevention,
Office on Smoking and Health
4770 Buford Hwy NE, Mail Stop K-50
Atlanta, GA 30341
(770) 488-5703
(770) 488-5848 (fax)
cch5@cdc.gov

Micah Milton, MPH
Centers for Disease Control and Prevention
Office on Smoking and Health
4770 Buford Hwy NE, Mailstop K-50
Atlanta, GA 30341
(770) 488-5728
(770) 488-5848 (fax)
mmilton@cdc.org

Abby Rosenthal, MPH
Centers for Disease Control and Prevention
Office on Smoking and Health
4770 Buford Hwy NE, Mail Stop K-50
Atlanta, GA 30341
(770) 488-5159
(770) 488-5848 (fax)
alr7@cdc.gov

CENTER FOR TOBACCO CESSATION

Linda Bailey, JD, MHS
Center for Tobacco Cessation/Cancer & Science Trends/American Cancer Society
901 E Street, NW, Suite 500
Washington, D.C. 20004-2037
(202) 585-3200
(202) 661-5750 (fax)
linda.a.bailey@cancer.org

Elizabeth Edsall, MSc
Center for Tobacco Cessation/Cancer & Science Trends/American Cancer Society
901 E Street, NW, Suite 500
Washington, D.C. 20004-2037
(202) 585-3217
(202) 661-5750 (fax)
elizabeth.edsall@cancer.org

NATIONAL CENTER FOR TOBACCO-FREE KIDS

Peter Fisher
National Center for Tobacco-Free Kids
1400 Eye Street
Washington, DC 20005
(202) 296-5469
(202) 296-5427 (fax)
pfisher@tobaccofreekids.org

Cyndi Lewis
National Center for Tobacco-Free Kid
PO Box 326
LaConner WA 98257
(360) 466-9208
(419) 793-5604 (fax)
clewis@tobaccofreekids.org

SMOKELESS STATES

Elaine Ishihara, MPA
SmokeLess States Grant Liaison
10629 59th Avenue South
Seattle, WA 98718
(206) 722-4833
(206) 722-9138 (fax)
elaine_ishihara@ama-assn.org

CONSULTANTS

Karen Rezai, MPH
APPEAL
439 23rd Street
Oakland, CA 94612
(510) 272-9536
(510) 272-0817(fax)
krezai@aapcho.org

Jane Ross, MBA, MPH
California Department of Education
1430 N. Street, Suite 6408
Sacramento, CA 95814
(916) 319-0200
Janebro@aol.com

Beth Ewy, MPH, CHES
Division of Preventive and Behavioral Medicine,
University of Massachusetts Medical School
55 Lake Avenue North
Worcester, MA 01655
(508) 856-2935
(508) 856-3840 (fax)
beth.ewy@umassmed.edu

Lori Pbert, PhD
Division of Preventive and Behavioral Medicine,
University of Massachusetts Medical School
55 Lake Avenue North
Worcester, MA 01655
(508) 856-3515
(508) 856-3840 (fax)
lori.pbert@umassmed.edu

Claryse Kami Nunokawa
Hawaii Community Foundation
1164 Bishop Street, 8th floor
Honolulu, HI 96813
(808) 566-5543
(808) 521-6286 (fax)
cnunokawa@hcf-hawaii.org

Maia Rogers, MPP, MPH
Health Policy Analyst
8070 E. Cedar Ave
Denver, CO 80230
(720) 236-5433
(425) 675-9975
malaya@attglobal.net

Doris Segal Matsunaga
Kalhi Palama Health Center
915 N King St.
Honolulu, HI 96817
(808) 791-6330
(808) 845-2413 (fax)
matsunagp001@hawaii.rr.com

Caroline Renner, MPH
Office of Alaska Native Health Research,
Alaska Native Tribal Health Consortium
4201 Tudor Centre Drive Suite 105
Anchorage, AK 99508
(907) 729-2925
(907) 729-2924(fax)
ccrenner@anmc.org

Ed Lichtenstein PhD
Oregon Research Institute
715 Franklin Blvd.
Eugene, OR 97403
(541) 484-2123
(541) 484-1108 (fax)
ed@ori.org

Eva Mathews, MPH
University of Arizona, College of Family &
Community Medicine, Arizona Health
Sciences Center
1450 N. Cherry Avenue
Tucson, AZ 85719
(520) 626-1087
(520) 686-1080 (fax)
evam@email.arizona.edu

Zenén Salazar
University of Arizona, Healthcare Partnership
Continuing Education & Training Unit, Arizona
Health Sciences Center
2030 East Speedway Blvd., Suite 120
Tucson, AZ 85719
(520) 318-7253ext. 117
(520) 318-7032(fax)
zenen@u.arizona.edu

Beth Stoneking, PhD, CPRP
University of Arizona, RISE
1450 N. Cherry Avenue
Tucson, AZ 85719
(520) 626-7473
(520) 626-7833 (fax)
bstoneki@u.arizona.edu

LINKING A NETWORK REPORT WRITING GROUP

Wendy Bjornson, MPH
Director, Pacific Center on Health and Tobacco

Christopher Anderson
California Smokers' Helpline

Pamela Powers, MPH
Arizona's Smoker Helpline

Elizabeth Laws, MPA
Pacific Center on Health and Tobacco

Abby Rosenthal, MPH
Corinne Husten, MD, MPH
Centers for Disease Control and Prevention,
Office on Smoking and Health

Sara Tifft, MBA
Ken Wassum
Group Health Cooperative,
Center for Health Promotion

Randi Lachter
Minnesota Partnership for Action Against Tobacco

Donna Warner, MBA, MA
Massachusetts Department of Public Health

Jenna Perego, MS
Utah Department of Health

Lezli Redmond, MPH
Center for Tobacco Research and Intervention,
University of Wisconsin Medical School

Susan Swartz, MD
Center for Tobacco Independence,
Maine Medical Center

1200 NW Naito, Suite 220 • Portland, OR 97209-2829
503-236-0361 • fax 503-872-9336 • email pcht@qwest.net • www.paccenter.org